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THE

MARITIME MEDICAL NEWS

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A MONTHLY JOURNAL DEVOTED TO MEDICINE & SURGERY

HALIFAX, NOVA SCOTIA.

Vol. XXI. NOVEMBER, 1909. No. 11

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Published by the MARITIME MEDICAL NEWS CO., LIMITED, Halifax, N. S.

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THE MARITIME MEDICAL NEWS

VOL. XXI., *NOVEMBER, 1909*, No. 11.

WORLD OF MEDICINE.

Massage in General Medicine.

J. K. Mitchell, Philadelphia (*Journal A. M. A.*, October 9), defines massage as the skillful manipulation of the body for definite therapeutic ends. In the main, the mechanical results of massage are those of active exercise. We can influence the circulation of the blood and lymph, can improve the tone and in some degree the bulk of muscles, increase the activity of peristalsis and digestive tract, aid the secretions, and if need be produce quiet and soothing effects. The superficial nerves can be directly reached and the deeper lying nerves and excretory organs can be, somewhat less immediately, reached. The chief dif ferences between massage and active exercise are that by the former we can not expect to add greatly to the power and volume of the muscles, and secondarily it makes no demands on the voluntary nervous system and we can thus avoid drawing on irritable and weak nervous centers. Its greatest value is in dieases that are due to altered metabolism and in which the digestive, absorbing or assimilating capacity is at fault. Its good eeffcts in hysteria and neurasthenia are due to this fact. The special forms of massage all have their influence, but their combination has more effect than when used separately. Some fancy manipulations used by professional masseurs are deemed by Mitchell more harmful than useful, as they irritate rather than sooth and can not have much effect otherwise on the individual. The vital, useful, alternative movements are the deep ones. After an hour's manipulation, especially after a week or so of treatment when the strangeness has worn off, the patient should be left in a non-disagreeable state of mild lassitude hardly to be called fatigue, usually with moderate drowsiness and feeling of well being. The neurasthenic "tired feeling" should be lessened. Gentle warmth should be felt and a sense of stimulation of the circulation, increase of appetite, improvement of digestion, and sounder and longer sleep. There is a temporary slight increase in temperature in most cases. Too long-continued manipulation of superficial rubbing may not have these good effects but may rather irritate the nervous patient. There is an absolute demonstrable increase in the flow of blood in any part, followed by an increase in the amount of urinary excretion and of the digestive secretions, and greater vasomotor control. An increase of red blood cells has been demonstrated. Light rubbing, slapping, and tickling will not produce these desired effects, but slow manipulations for fifty minutes will, and when they are not produced, we may conclude that the right sort massage was not employed. Among the disorders which are especially benefitted by the method, Mitchell mentions chronic constipation, chorea, shaking palsy,

sprains, and even peritonitis of which he mentions an example in a patient of Dr. Goodell's in whom laparotomy showed a mass of matted adhesions and good functional activity was produced later by massage. Among other uses of this form of treatment, he mentions its aid to the circulation in early cardiac incompetency, in convalescence from acute and exhausting diseases and in healing of fractures. In conclusion, Mitchell mentions the modern fad of osteopathy which amounts to a sort of ferocious massage. The feelings of the osteopath are, he says, hurt when one calls his manipulations massage, but Mitchell adds "it is rather hard on massage." If massages were properly understood and properly appreciated, however, the osteopaths would never had the success they have had. They have found out and made use of the immense value of massage and, as a result, are teaching the public, without intending to do so perhaps, the important lesson of the value of bodily exercise, but that they do so in such a manner as to cause frequent damage and almost constant danger to another matter.

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The Care of the Nursing Breasts. George E. Abbott, of Pasedena, Cal. (*Medical Record*, Oct. 21, 1909), shows how the breast is prevented from attaining the normal development and thus secreting the normal amount of milk by the pressure of the ribs against the branches of the mammary artery as it passes out between the ribs, the weight of the breasts causing this compression by dragging on the vessels. If the breasts be supported the circulation is normal and much more milk will be secreted. By lying upon the nursing side while nursing the infant the greatest amount of blood pass to the breast during lactation. The breasts should both be nursed at each feeding, instead of alternately. Thus the breasts never hang flabby and will be firmer and of better shape after nursis over. In using massage of the breast it should begin around the nipple and end at the circumference. The nipple should be massaged with lanolin cream before each nursing, so as to make it soft and pliable for the infant. Much pain is saved in this way. In girls whose physical development is slow and who are nervous and high strung, the nature of the menstrual period should be explained and an attempt made to awaken the mother instinct toward the doll.

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Gastric Symptoms of Gall Bladder Disease. Harry Adler, of Baltimore, Md. (*Medical Record*, October 10, 1909), says that there exists a large grooup of gall-bladder cases in which the symptoms are all referable to the stomach, and treatment of these symptoms gives relief; but in which later typical gallstone colic supervenes. The author gives illustrative cases. In cases of obscure abdominal pain, examination of the urine will show traces of bile. The test is made by the action of tincture of iodine diluted with alcohol run down upon the urine, which produces a fine green ring of biliverdin. By this test we may show chyluria in cases in which jaundice does not exist.

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The First American Hospital. James J. Walsh, of New York (*Medical Record*, October 2, 1909), states that the first hospital ever built in America was erected by the Spaniard Cortez in the city of Mexico in 1524. It was endowed out of the revenues

obtained from the properties conferred on him by the Spanish Crown for his services in the conquest of Mexico. The endowment was so arranged that it still exists, and is paid at the present day. A supervisor is named by the lineal descendant of Cortez at present. In this hospital women occupied positions as nurses and physicians, and in their care were all cases of obstetrics and women's diseases. Considerable was known by the Indians of medicine. The Mexican hospital is a fine building, with arcades and courtyard. It is an interesting landmark in the history of hospital construction and administration.

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Mr. Dooley on Doctors. We are not far from the state of things described by Mr. Dooley. Readers of that acute philosopher may remember how he goes to a doctor who takes his temperature, examines his blood, and so forth. "By that time (says he) I'm scared to death, an' I say a few prayers, whin he fixes a hose to me chest an' begins listenin." "Annythin' goin' on inside?" says I. "'Tis ye'er heart," say he. "Glory be!" says I. "What's th' matther with that ol' ingine?" says I. "I cud tell ye," he says, "but I'll have to call in Dock Vinthricle, th' specyalist," he says, "I oughtn't be lookin' at ye'er heart at all," he says. "I niver larned below th' chin, an' I'd be fired be th' Union if they knew I was wurrukin' on th' heart," he says. So he sinds f'r Dock Vinthricle, an' th' dock climbs me chest an' listens, an' then he says: "They'se somethin' th' matther with his lungs too," he says. "At times they're full iv air, an' again," he says "they ain't," he says. "Sind f'r Bellows," he says. Bellows comes and pounds me as though I was a roof he was shinglin' an' sinds f'r Dock Laporattemy. Th' dock sticks his fingers into me side. "What's that f'r," says I. "That's McBurney's point," he says. "I don't see it," says I. "McBurney must have had a fine sinse iv humor." "Did it hurt?" says he. "Not," says I "as much as though you'd used an awl," says I, "or a chisel," I says; "but," I says, "it didn't tickle." The end is "They mark out their wurruk on me with a piece iv red chalk, an' if I get well, I look like a red carpet."—

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Nervousness A. Cramer (*Wien. med. Klin.*, May 23rd and 30th, 1909), discusses the causes, endogenous and exogenous, of nervousness—that is, of neurasthenia, of endogenous nervousness, and of hysteria—together with the methods of dealing with the condition. In considering the causes of nervousness a most striking point is the extreme variability of the individual in the power of resistance to harmful influences, whether they are endogenous or exogenous in character. Of endogenous causes the most important are those which lead to a lowered resistance in the child, as, for instance, a state of cachexia in the parent due to whatever cause. The exogenous causes are extraordinarily numerous, and may begin to operate at birth. Many depend on the ordinary customs of life. The fact that rest is necessary for children and adolescents is not sufficiently recognized. Overstrain at school is probably not so common as is supposed; it would, however, be diminished if more individualization were possible, and children were not kept at work for which they were not adapted. In adults, the influence of hysterical or nervous people, the reading of impure literature, hypnotism, sexual irregularities and excesses, the

difficult struggle for existence, the action of acute and chronic poisons—for example, alcohol, narcotics, lead, mercury—infectious toxins, and trauma, are among the many causes. It is evident that, as a rule, not one single cause but a combination of causes leads to nervousness, the exogenous causes being less conspicuous the greater the predisposition of the patient. The endogenous causes injure the vital energy of the neurone initially, so that the normal biotonus is easily lost, while the exogenous causes either injure through chronic over fatigue the self-regulation of metabolism in the neurones or injure the biotonous by the action of poison, or directly as in shock or trauma. In dealing with this, as with so many other conidtions, prophylaxis is the most effective measure. As regards the endogenous causes it is not possible to improve the race by marrying only suitable individuals, nor is our knowledge of the laws of heredity adequate for the purpose. Hygienic measures and the fight against tuberculosis and venereal disease are methods of dealing with some of the endogenous causes. Cramer considers also that the army and the marine service raise the standard of health, and that an increase of nervousness would be observed if life in the service were done away with. The measures directed against the exogenous causes are suggested by the list given. When nervousness is already present, but to a slight degree, rest and change are usually sufficient to restore the normal equilibrium of metabolism in the neurones, and bring about recovoery. Unfortunately for the poorer classes this treatment is difficult to put in practice, and the author suggests the possibility of some form of insurance by which it could be brought within the reach of poor people. In the severer cases, and where a marked predisposition exists, treatment must be continued for many months, even from one to two years, before the patient, after many relapses, is again fit to earn a living. For richer people there are many private sanatoriums in which, if the treatment is not too rigidly after a pattern, a good result is to be expected. There is a great lack of such sanatoriums for poor patients. Sanatoriums, under medical supervision and supplied with all the requisite neurological health apparatus, and above all with plentiful opportunity for gymnastics and occupation, may become a source of regenerative strength for nervous patients. —B. M. J.

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Duodenal and Gastric Ulcers. Duodenal and gastric ulcers have so many points in common that there are really no characteristics by which they can be differentiated; and very often a differential diagnosis is immaterial, so long as an ulcer is recognized. Latent duodenal ulcer givss rise to little or no pain, has no typical symptoms and is generally unrecognized until suddenly there is a hæmorrhage, which is liable to be severe, and blood is vomited from the stomach and passed from the bowels. This blood may be unchanged or greatly altered by the action of gastric and intestinal juices. That passed from the bowels may have a tar-like consistency. Severe hæmorrhage occurs in about one-third of the cases. Before there is a hæmorrhage, the appetite and stools are generally normal; dyspeptic symptoms are rare and there may be diarrhœa, although constipation is the rule. Vomiting is rare and, barring the blood, is not characteristic. There may be an increased, a decreased or an absence of hydrochloric acid. In gastric ulcer pain is

supposed to be relieved by vomiting; while in duodenal ulcer there is no relief from vomiting and it is claimed by some that in duodenal ulcer the pain comes on later, say four or six hours after eating, and that it is situated further to the right; but none of these points are by any means reliable. In pyloric ulcer there are pain, gas, acidity and the vomiting is more intense; while in duodenal ulcer the pain, gas, acidity and vomiting are not so well marked and the pain resembles more that of gall-stones. Icterus is an exaggerated symptom of duodenal ulcer, as it is rare and when present means some complication.—H. E. Lomax, in *Albany Medical Annals.*

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Aseptic Surgery. The last few years have witnessed a gradual but steady increase in the popularity of aseptic as opposed to antiseptic surgery. This has been a gradual evolution, and we can trace the various steps by which it has been brought about. Lord Lister in this country found that certain strong chemical compounds had the efiect of destroying these micro-organisms, and devised methods by which he claimed suppuration could be reduced to a minimum. He met with the opposition which is the experience of reformers; but eventually he gained the day, though it was some years before his teaching was universally accepted. This was the result of two factors: his original methods, *e. g.*, the carbolic spray, etc,. were admittedly inadequate; but further, imperfect as they were, they were not properly applied by the surgeons who first used them. One hears, for instance, stories of surgeons in the early days of antiseptic surgery who operated with a carbolic spray, but omitted to cleanse their hands, and then published their results to prove that Lord Lister's work was incorrect.

In spite of these early difficulties, however, antiseptic surgery made the progress it was bound to do, and a new variety of antiseptic was constantly discovered. Of these, carbolic acid and the salts of mercury, either mercury perchloride or mercuric potassium iodide were the ones that came into general use.

By their means a very high percentage of operations without suppuration could be guaranteed; but they had certain disadvantages. Cases of poisoning by mercury after irrigating large suppurating cavities with corrosive sublimate or biniodide were reported; and it was argued that the introduction of such powerful chemicals into the peritoneum, for instance, was likely to diminish its vitality. Some means was therefore sought by which pyogenic organisms could be eliminated from the field of operation without as far as possible the aid of chemical re-agents. Thus the rise of aseptic surgery.

Heat of a sufficiently high degree is admittedly the best of all means of sterilisation, and everything connected with a surgical operation can be submitted to this with the exception of the patient's skin, the surgeon's hands, and certain forms of ligature. All instruments to be used must be boiled. Some surgeons say that to boil a knife destroys its edge. This is partially true, but one boiling is not sufficient to make it useless, and after each operation it should be reset. Those who object to boiling scalpels usually pass them through a carbolic solution 1 in 20 and keep them in methylated spirit, but this is a departure from the aseptic method.

All dressings, towels, swabs, etc, should be placed in specially made

drums, with a visor arrangement which can be opened during the sterilising process and shut afterwards. The drums are placed in an autoclave and heated to 115° C., their contents being thus rendered absolutely sterile. The mackintoshes which are placed on the patient should be subjected to the same treatment. This can easily be done by employing instead of ordinary mackintoshes large sheets of specially prepared jaconet.

One great advantage of this system is that it is not absolutely essential to carry about large trays to place one's instruments in. A sheet of the sterilised jaconet may be laid over a table and on this again a sterilised towel on which all instruments can be put when they are taken out of the steriliser. If it is preferred to keep them in fluid, sterilised normal saline solution is the best to employ.

With regard to the surgeon's hands, much controversy has ranged round the question of india-rubber gloves. Arguments have been adduced against them that they impede the operator and increase the time of operation; that if a glove is accidently pricked by a needle there is a chance of the wound becoming thus contaminated. In the writer's experience it is not more difficult to operate with gloves when one is once accustomed to them, provided that the gloves fit well and are properly put on. The best way of putting them on is to fill them with saline solution, insert the hand, and then hold up the hand so as to allow the fluid to run out at the wrist. Some surgeons prefer to cover the hands with liquid and then put on the gloves. This is an easy method, but when the glove is on it does not adhere firmly to the fingers, and the difficulty of the operation is undoubtedly increased thereby. The argument that accidental pricking of the glove may lead to contamination of the wound is met by the rule that the hands must always be cleansed as carefully as if one was about to operate without gloves.

In one particular only are we now unable to dispense with chemical antiseptics, and that is in the preparation of the patient's skin; and to ensure successful asepsis this is particularly important. The success of operations where asepsis is absolutely essential to the welfare of the patient, such as in opening the knee-joint, depends largely on the thoroughness with which this is done. It is well, therefore, to begin the preparation two or three days before the operation by shaving the part if necessary and theoroughly cleansing it with soap and water. It should next be rubbed with ether to get rid of fatty debris, and swabbed over with a solution of mercuric potassium iodide in spirit. Finally it should be wrapped in a biniodide or carbolic dressing covered with jaconet to keep it moist, which should be changed daily until the day of operation.

If all these precautions are observed the percentage of clean cases which suppurate can be reduced to a minimum. The individual factor varies with every surgeon, but in most tables of statistics of operations performed aseptically the number of cases which suppurate amount to less than 5 per cent.—*Hospital.*

EDITORIAL.

AT the recent meeting of the Canadian Medical Association in Winnipeg, two matters of great interest to the profession received marked attention. The first of these was the question of a common Register for the whole Dominion, a question which implies interprovincial reciprocity. As our readers are aware, many attempts have been made to solve the difficulties in the way of securing a Dominion Register. Every one admits that our present system is a bad one, it is clumsy, irritating and unjust. To the ordinary man it must seem preposterous that a medical man who may have practised for years with success in one of the provinces of our Dominion is considered unfit to undertake practice in another province, until he has passed an examination by the board or council of that province. It must seem unjust that a young man who has passed successfully the examinations of the Universities of McGill, or Toronto, or Dalhousie, or Manitoba, should be excluded from practice in any province, until he has passed the examining board of the province. This unfortunate state of affairs, which is little short of scandalous, is to a large extent the result of the unhappy arrangement whereby under the Act of Confederation, education was left to provincial authority, and not made a federal charge. We all remember the great effort made by our distinguished colleague, Dr. Roddick, of Montreal, to secure a common registration, by means of the Canada Medical Act. This Act, which received the assent of Parliament in May, 1902, provided for the establishment of a "Medical Council of Canada," and among the purposes of the Council, were the establishment of a qualification in medicine which should empower the holder thereof to practice in all the provinces of Canada, and the establishment of a register for Canada of medical practitioners; also for the establishment and maintenance of a board of examiners who should examine and grant certificates of qualification. Now, as the methods and standards of medical education are provincial and not federal in their control, it would be necessary, before the establishment of a Dominion Register, that the legislature of such province should enact that registration by the Council should be accepted as equivalent to registration under the laws of that province. If then, each provincial legislature had so decreed, the Medical Council, representing all the provinces, would have come into being, and a common register would have been established. But all the provinces did not agree to this, and as the Act now stands, it is inoperative "until all the provinces shall have legislated in effect as aforesaid." And so that road is still closed.

But there is another road which may be tried. And this is by means of the amendment secured by General Laurie to the Medical Act of Great Britain. An Act was passed in Britain in 1886 providing for reciprocity between the Mother Country and such self-governing colonies as might comply with certain conditions. This was done expressly to facilitate the admission of medical men from the Colonies to practise in Great Britain, or in the Imperial service. This Act expressly stipulated that if a colony had a provincial and a federal organization, such reciprocal arrangements should be entered into with the fed-

eral, not the provincial government. In the case of the then unfederated states of Australia, reciprocity was arranged for, but, as education is not under federal authority in Canada, reciprocity was denied us. As it was held impossible to amend the "British North America Act" of 1867, General Laurie, then a member of the Imperial Parliament, but who has always shown great interest in affairs in this country, brought in a bill to amend the Medical Act, and after several unsuccessful attempts, gained his point, so that now each province, for the purpose of medical registration is regarded as a separate British possession. The Medical Council of Great Britain welcomes this change, and is willing to enter into reciprocity with any of the provinces of Canada whose legislatures pass the necessary enactment, and on the understanding that the provinces so entering into reciprocity with Britain, reciprocate also with each other. In the Province of Nova Scotia the enabling legislation has been passed, and any one on the Medical Register of Nova Scotia may be registered in Britain, and conversely any one on the British register can be registered in Nova Scotia. Thus far Nova Scotia is the only province which has taken advantage of the Laurie amendment. It was understood that the province of Quebec had also complied with the provisions of Imperial reciprocity, but we understand that, while the Medical Council of Quebec receives registered British practitioners, who have been educated in Britain, it refuses to register medical men educated in other Canadian provinces who may have registered in Britain. If this be really their position, they cannot expect reciprocal registration with Britain.

It is at once evident that, under the Laurie amendment as viewed by the Medical Council of Great Britain, the door is automatically open to a Dominion register. For, if each province passes the necessary legislation for reciprocal registration with Great Britain, it *ipso facto* recognizes that each other province is on the same basis, has practically the same standards of medical qualifications, and "things that are equal to the same thing are equal to one another."

But, if one province takes the stand of refusing reciprocity to its sisters in the federation, the way is blocked as before.

The great difficulty in the working of the Roddick Act as it appears to us, lies in its examining board; indeed, the difficulties here seem to us insuperable. And it does not seem possible that any progress can be made until some common platform can be reached, and reciprocal relations established between the various provinces. If, and when that platform is reached, the question is solved, at least as regards Canadian graduates.

The other matter which received marked attention was the proposed Journal of the Association. This is a question which has for several years increased in importance. The advantage and indeed the necessity for such a journal is very widely felt, and many of the leading members of the Association believe that the establishment of a good journal, which should be the mouthpiece of the profession throughout Canada generally, would do more to bind the profession into a homogeneous body, would do more to generate a Canadian medical *esprit de corps* than anything else.

Last year the Association received its charter of incorporation at Ottawa and is now in a position to own property and conduct a journal.

The whole matter rests at present with the Finance Committee of the

Association, and we shall doubtless soon know their decision. It is hoped in some quarters that the first number of the journal may appear in January of next year.

We believe the proposal of the finance committee is, briefly, as follows:

First, that the annual dues of the Association shall be five dollars, and that this should be paid by every medical man in the Dominion, whether he comes to the annual meeting or not, at least by every one who wishes to be a member of the Association, and that, in order to save trouble and expense, this fee should be collected through a bank, as is now done in this country in the case of the dues of the Canadian Medical Protective Association, and of the branches of the British Medical Association.

Second, that in return for this fee of five dollars, each member of the Association shall receive a copy of the journal.

Third, that for each five dollar fee received by the treasurer of the Association, fifty cents be remitted to the treasurer of the local or provincial association, on the same plan as holds in the British Medical Association.

We hope to return to this subject of the Journal of the Canadian Medical Association in our next issue, but in the meantime we may point out one advantage which would accrue to the Medical Society of Nova Scotia, under the plan just outlined. At present the annual income of the Society consists of the annual fee of one dollar paid by each member in attendance, and our average annual income is barely fifty dollars. If even one-half of the profession in Nova Scotia were to join the Canadian Medical Association, the treasurer of our Society would receive from the funds of the Canadian Association a sum of at least one hundred dollars.

A SYNOPSIS OF THE PREVENTION AND CURE OF TUBERCULOSIS SUITABLE IN NEW BRUNSWICK.

By PERCY E. BUTLER, B.A., M.D.

(Read before the New Brunswick Medical Society, 1909.)

AT a time when scientific medicine has done so much to stay the inroads of the acute diseases, when the plagues of Egypt are halted at the borders of civilization and even leprosy with all its loathsomeness, yields to preventitive means; when the brightest minds of the 20th century are battling to eradicate the great white plague in its multiple forms from our midst, and hope is beginning to arise of ultimate success, should not a young and growing province like New Brunswick take heed and safeguard the lives of its subjects by suitable means?

On the medical profession devolves the duty of imparting the required knowledge necessary to dissipate the ignorance and indifference of governing bodies: to point out the ravage daily wrought and the means by which it can be prevented and to educate the people so that results, in the form of appropriate legislation will follow.

To this end it is therefore necessary to understand how this disease originates, how propagated and how prevented, and the suitability of this province for a cure.

ETIOLOGY.—The rational treatment of any disease depends on a due appreciation of the causative factors. Especially is this true of consumption and for that reason its etiology will be briefly referred to before taking up the means for prevention and cure.

DIRECT CAUSE.—The presence of tubercle bacillus and its multiplication in the human system is the direct cause of tuberculosis. That the tubercle bacillus can be transmitted directly through the male is hardly probable as has been repeatedly demonstrated experimentally. In the lower animals it has been detected in the ovum and is undoubtedly carried in many cases through the placental blood stream of a tuberculous mother.

INOCULATION.—On many occasions inoculation has occurred through vaccination, wearing the apparel of consumptives or from scratches of contaminated articles. The post-mortem wart (or verruc-amicrogenica) seen on the hands of hide sorters is undoubtedly a good example.

INHALATION.—But by far the most common mode of invasion is by the inhalation of the fine particles of sputum coughed up by consumptives, which becoming attached to fine particles of dust are carried into the system through the lungs.

INGESTION. — Infection may also come through the ingestion of the milk and meat of infected animals. Briefly then, tuberculosis may be contracted directly from the mother, through inoculation, by inhalation, and by ingestion.

INDIRECT CAUSES. — Of indirect causes may be mentioned:—

Heredity First. — First a predisposing weakness in persons born of tuberculous parents. In them there is a lowered power of resistance in the cells of the body so that when brought

in contact with the exciting cause they are easily overcome.

Environment Second.—Dwellers in cities, crowded, poorly lighted and ventilated houses, work-shops, asylums, foundling institutes and all public buildings are liable to contract the disease. While those living in wet, poorly drained districts, along the shores of a large body of water, with the prevalent wind, landward, carrying an excess of moisture, are subject to catarrhal affections which forms a good culture media for the bacilli.

Occupation.—Of the occupations, dust ladened factories, glass works, stone-cutters shops, mines, etc., are fruitful sources of infection.

Diseases.—Consumption may follow in the wake of certain zymotic diseases such as whooping cough, measles, influenza, and scarlet fever.

Treatment.—The treatment must be one of prevention, rather than a cure. As it would be folly to build a house without a foundation, so it would be a waste of energy and money to attempt a cure without first instituting means to prevent its dissemination. The prevention lies with our law-makers; the cure with proper hygiene, food, fresh air and suitable environment. In New Brunswick with the exception of a few low-lying counties, the surroundings are equal to more widely heralded sanatoria. To prevent, should therefore be the watchword. For this both the Federal and Provincial Houses must be called upon to frame new laws and see that they are enforced. No half-hearted measures will avail.

Immigration. — Daily immigrants, many of whom carry the germs of consumption in their system, are entering the country, stopping at public houses and travelling in public conveyances. Unless the case is well marked they pass easily through the hands of the inspectors and go to augment the many already within our boundaries. Can this leak be stopped? Deportation would seem to be the only method, and this is difficult to carry out on account of the uncertainty of diagnosis in the incipient stages, and the many ports of entry. The evil might be remedied by a strict medical examination, based on the lines of a first-class insurance company, both at the point of embarkation and debarkation, with transportation at the expense of the company carrying them. With those arriving from the United States by rail, examination enroute would be difficult, but a report from a qualified physician to the health authorities at destination would be practicable. Views like these might no doubt call forth considerable cheap sentimentality, especially where the question of deporting, all who cannot pass a rigid examination is considered, but it is a matter of the greatest good for the greatest number, and economising the strength of our people by receiving only the healthy, leaving to their own country the care of their afflicted.

Marriage Laws.—"Noli me tangere" would be the cry if any restrictions on the sacred rites of matrimony were called for, but following the lines of the etiology previously cited, what more senseless than seeking to eradicate tuberculosis when it has been demonstrated that transmission through the ovum may occur and propagation through the placental blood stream is fairly common. Many marriages are solemnized with either one or the other of the contracting parties tuberculous and sooner or later both contract it, while the offsprings if viable, show a lowered resistance and a fit soil for future developments, a

new link in the never ending chain. Could this not be averted by requiring a health certificate before issuing a marriage license? Undoubtedly many would rebel but some good would be accomplished.

Public Works and Conveyances.—The means of public conveyance in New Brunswick are limited to railways, boats, and street cars. These are kept in a fairly sanitary condition, still a few extra precautions would further minimize the danger.

For all railway companies, a sanitary inspector would be a valuable asset, whose duties would consist of the supervision of construction, lighting, ventilating and cleaning of stations and cars and enforcement of rules regulating expectoration on the premises. The chance of infection on the day coaches is not so great as might be supposed, and with a little care could be entirely obviated. Drinking cups should be abolished. In sleeping cars ventilation is essential and changing and cleaning of bedding after each occupant should be insisted on. These rules would also apply to boats and steamers, while in street cars over-crowding and expectorating on the floors should be strictly prohibited.

Public Dwellings.—In public boarding-houses and hotels special attention should be paid to the beds and all accessory furnishings such as draperies, lace curtains, etc., removed from the sleeping rooms. In cleaning, the dust should be disturbed as little as possible. Periodical fumigations might also be practised. Theatres, concert-halls, churches and schoolhouses should be properly ventilated and frequently fumigated. Dance-halls should receive special attention.

Public Work.—In factories, workshops, department stores and all places where many are employed, the care of the employee should be paramount and strict rules for the preservation of sanitary conditions enforced. The buildings should be well lighted, heated and free from dampness and proper means instituted for keeping the atmosphere clear of dust, smoke, gases, and nauseous odours. Too long confinement of employees should be prohibited, and labor by minors forbidden. Frequent inspection by government or municipal officers should be practised, and no one afflicted with consumption employed, but suitable provision made for their maintenance by government pensions and the establishing of farm colonies. The soldier and the sailor while still in the prime of life receives this allowance from a benign government. The old men's annuity scheme is being exploited but the poor unfortunate victim of the white plague must earn a living for himself and family, dragging out a miserable existence and endangering the lives of others.

Temperance and Immorality.—To the temperance workers and ministers must be left the work of combatting intemperance and immorality. Two great evils that yearly through katabolic action on the body cells, lower their vitality and lend a hand to the invading germs.

Education.—On the education of to-day rests the burden of the preservation of future generations. It is therefore necessary for them to be thoroughly conversant with the duties involved. They should be in a position to answer at least six questions, viz.:

1st. By what means may tuberculosis be detected in its early stages in children.

2nd. How detected in the teachers.

3rd. What instructions should the teachers receive in regard to the health of children under their care.

4th. What instructions should the pupils receive.

5th. What instructions should be issued to school boards.

6th. What changes could be made in the school law that would tend to preserve the health of the children.

No. 1 and 2.—Few members of the Board of Education are qualified to answer the first and second questions without first consulting competent medical authorities. From them they would learn that tuberculosis, especially in its early stages, is very indefinite, and can only be made out after careful inquiry and examination. The so-called tuberculosis diathesis, distinguished as phlegmatic and sanguineous is easily distinguished, but this is only presumptive evidence of future developments. The family history and surroundings may serve as a clue or may be entirely misleading. The subjective symptoms of cough, expectoration, loss of weight, weakness and sweating with hectic fever may be absent or only the first present, expectoration may be scanty or absent until late in the disease. Wasting weakness, sweating and fever not pronounced. The physical examination may be positive or negative. If sputum can be secured microscopic examination may show the presence of bacilli and settle the diagnosis. The tuberculin reaction would be of value but is not practicable. While determining the opsonic index could only be carried out in a few instances as the technic is to elaborate at the present time. The cuti-reaction of crude tuberculin recommended by von Pirquet is still in its infancy but presents bright possibilities.

With the present means at our command and a strict medical examination of all pupils before registration, could be accomplished to maintain the health of the schools besides place the weak under more favourable conditions for recovery.

3rd. *Instructions to Teachers.*—Every teacher whether 1st, 2nd, or 3rd class if instructed in fundamental principles of ventilation, heating, lighting and cleaning of schools, the care of cloak-rooms and arrangement of seats, physical culture suitable for all ages, the care of play-grounds and the knowledge of healthful games, could do much to conserve the health and increase the vital forces of every pupil.

4th. *Instructions to Pupils.*—When the pupils reach an age at which subjects pertaining to health can be understood, daily lectures on the importance of fresh air, cleanliness, proper exercise and eating should be given. Text books covering these subjects are at present in use. Beginning with the lower grades a physical culture drill planned to encouarge deep breathing and develop the lungs carried out daily, in the open air when the weather permitted would be of inestimable value.

5th. *Instructions to Trustees.*—Written instructions covering the different forms of buildings suitable in each locality, showing forms of arranging rooms lighting, heating and ventilating, with construction of out houses should be furnished by the Board of Education to the trustees of every district. Advice might also be given as to the locality of schoolhouse, and laying out the grounds.

6th. *Amendments to Educational Law.*—Probably no amendment of the school-laws would be productive of so much good as the inauguration of medical supervision of school children. This need not necessitate much additional expense to the people or government. At the expense of the parents a certificate of health issued by a medical appointee, before regis-

tration of pupil and inspection of schools at stated intervals would not only protect the healthy scholars, but would be of value to all rejected as a means for building up their constitution would be instituted, while private tuition without the same exactions could be carried out at home, until such a time arrived when their condition no longer debarred them from public schools. By issuing printed regulations for medical certificates less chance for mistakes would arise and less discord produced.

The Education of the People.—With suitable education of children along the lines of preventitive treatment previously mapped out, the education of the adult population of the future would be assured, but that is a matter of years and valuable time has already been lost. Means whereby the interest of the people may be aroused is therefore essential. Work towards some good has been accomplished. In St. John and some of the counties, societies for the prevention of tuberculosis have been organized, but to be successful they must be formed in every county in New Brunswick. The separate parts of a powerful machine will then be available, later by uniting these parts by committees from each, a resistless engine of good will be produced, all powerful and ready to grapple with the many government propositions necessary to the end in view. No single organization will avail except locally. Once united as a Supreme Lodge of the New Brunswick societies for the prevention and cure of tuberculosis, with lecturers touring the country and literature mailed broad cast gratifying results must follow.

Board of Health.—Taking up the work of the Provincial Board of Health, a condition bordering on inertia is found to exist. No steps have been taken to keep pace with the requirements of the times.

With regard to the cleaning of houses occupied by consumptives the law is almost criminally negligent. Fumigation and cleaning is not deemed necessary, yet probably no more fruitful source of infection exists. A large percentage of cases could be prevented if due attention was paid to these houses.

As soon as a case could be diagnosed (and the Board of Health should facilitate the work of diagnosis by bacteriological laboratories, etc.),* it should be reported to the local board, who should at once placard the house, not, however, with stereotyped placard of scarlet-fever, etc., but a printed notice stating the character of the disease and a note of warning and advice to visitors. A strict quarantine need not be insisted on, as it would only add to the hardships of the patient. In addition, the local board should have in its possession for distribution, literature dealing in a plain, concise form with modes of prevention. These would not only be of educational value to the community and to the members of the afflicted household but of value to the physician in charge, especially where ignorance and carelessness are to be contended with.

Careful attention to dairy and beef cattle and the importation of infected herds, also require some consideration.

*Note.—Since writing this I notice that the Provincial Government has amended the Board of Health law and that it now has regulations similar to above.

Curative Treatment.—The census returns of 1901, vol. 4, published in 1905, gives the total number of tuberculous cases in New Brunswick as 539, distributed as follows:

Restigouche	7
Gloucester	39
Northumberland	51
Kent	66
Westmoreland	77
Albert	22
St. John and City	63
Charlotte	48
Kings	36
Queens	25
York	52
Carleton	22
Victoria	31
Total	539

Of this number classified according to lesion the report shows—

Tuberculosis of Larnyx	4
" " Meninges	9
" " Lungs	485
" " Abdomen	10
" " Spine	2
" " Hip	2
" " Knee	0
" " Other organs	3
General Tuberculosis	18
General Tuberculosis glands	5
Total	539

That these figures are inaccurate, and far below the actual number there can be little doubt. Madawaska was was certainly not immune. St. John city alone had 113 in 1900 and 115 in 1908, almost double the census returns for city and county in 1901. In like ratio the number of cases germinating in New Brunswick at the present time cannot be less than 1,000, or one to every 361 of the population.

To deal with this number in a thorough and scientific manner is therefore the problem awaiting solution.

Treatment.—Twenty-nine of the cases cited 1901, viz.: Those with lesions in the larnyx, meninges, abdomen, spine hip and other organs and doubled to 58 for accuracy in 1908, could receive home and hospital treatment, which would consist of local and general medication, proper nourishment, air and operative procedures when required.

The remaining 490 or 980 for 1908 classified as consumption and tuberculous glands would require treatment, either at home or at sanatoria.

Treatment of cases at home is unsatisfactory. Not only is it difficult to carry out without specially trained assistance, but there is always danger of transmitting it to other members of the family or household.

Sanatorium treatment has not yet been instituted in New Brunswick, but a commission to deal with this matter has lately been appointed by the Provincial Government which will no doubt soon return a full and complete report. In the meanwhile, it might not be considered presumptive to outline the plans feasible before drawing this paper to a close.

For this purpose it will be necessary to consider the climatic and topographical conditions in this province and food supplies available. The forms of structure most serviceable, and whether under Provincial or Municipal control.

Climate.—An ideal climate for a consumptive, is one of a fairly equal temperature the year round, with no great excess of heat or cold, an abundance of sunshine, no sudden changes and not too much moisture. New Brunswick is not favoured with these conditions, sudden changes are common. The average duration of sunlight for a year not over eight hours daily along the sea-coast, an excess of moisture is the rule, and as the statistics of 1901 show here the greatest number of cases occur. True, a more thickly settled belt may account for this as also the manner of living. Along the North Shore and in Westmoreland County the ratio is high,

but in these counties the poorer class of the French-speaking population reside, living for the most part in small, over-crowded and unsanitary houses. Still Charlotte County not thickly settled in any part has a large percentage of cases, while York and other inland counties rank very high. In the counties to the northwest the average is much lower, although the reason may not be lack of material, but rather failure to report the cases. Compared to the Adirondacks and other sanatoria along the Atlantic seaboard there is little difference in the climatic conditions. The natural drainage in all parts is good.

Altitude.—A high altitude, which for years has been considered of prime importance, can be attained in some part of every county.

Nourishment. — Good, wholesome nourishment, consisting of milk, meat, eggs, etc., can be obtained any place. There are few high bred cattle and for that reason tuberculosis is not so common among them as in other provinces.

For sanatorium purposes New Brunswick is in every way as favourably situated as in many more widely advertised localities, and one county equally as good as another.

Sanatoria.—The question now to be considered is which will result in the most good, a centrally situated sanatarium supported by the government or a separate sanatarium for each county, aided by government grants but controlled by the municipal councils.

Provincial Sanitarium.— To accomplish the good intended a provinsanitarium must be constructed to accommodate all consumptive cases at present in New Brunswick. Two forms are now in use in other countries, one large hospital, or a colony of small buildings, with a small central home for nurses and doctors.

Supposing one building was contemplated. This theoretically should be constructed to accommodate one thousand patients in all stages of consumption. It should be situated in a central part of the province, easily accessible to all. Built of the best material for use the whole year,, adapted for the maintenance of perfect cleanliness, simply furnished yet with an air to comfort, and surrounded by farms, so that food could be secured at the lowest possible price and to afford some occupation for mild cases.

This would not be practicable for many reasons: 1st. The cost of construction and maintenance would be enormous. 2nd. A central point accessible to all could not be obtained. Many would not be in a financial position to travel one hundred miles or more. Others would be unwilling to go so far from their friends, while the friends would object to their going unless they could see them often. 3rd. And this is the most important. Perfect cleanliness could not be maintained. No matter how much fumigating was carried on or how stringent the regulations, within the course of a very few years, the whole building would be infected.

With the formation of a central tuberculous colony the first objection alone would contra indicate, and the distance for many would certainly constitute a formidable obstacle.

Municipal.—Municipal control of tuberculous colonies would be of greater advantage and reach those that a central colony or sanitarium would not.

In my treatment of these cases, during the last eight years, I have advised and had constructed whenever possible, small cottages at some

distance from the houses, at a cost in no case exceeding thirty-five dollars.

These are generally 12 by 14 feet with a seven foot post, allowing with the roof, air space of over 1,000 cubic feet. They are boarded up a distance of four feet at the sides and ends. The remaining three feet closed by windows, which can be opened or closed at pleasure of occupant. A door for entrance is left at one corner. For covering, tarred paper, or shingles are used and for winter purposes the walls on the inside may be sheathed with planed boards.

The furniture consists of a cot, bed, chair, wash-stand and linoleum covering for the floor. For heating a stove may be used.

The greatest obstacle for further treatment is in securing trained attendance, and enforcing the regulations in regard to expectorating, forced feeding, and bathing. Besides it is difficult to keep the patients under control as they are very liable to get impatient and resort to all kinds of nostrums, patent medicines, etc.

These disadvantages could be obviated by forming colonies in a central position of every county. Each patient having their own cottage constructed. A small cottage would also be necessary for assistance and nurses from which the others could be heated in winter, if connected by hot water pipes. Any competent medical practitioner in the vicinity could have charge. Government aid would be necessary at first but as most inmates would be in a position to pay for their maintenance, this need not be very large. When the cottages are no longer required they could be burned and built anew for the next arrival, thus averting all danger. The nearness to the homes of all would be of a decided advantage, as regular visiting days could be allowed and thus no aversion towards sending friends there would be felt. Thus municipal control of all sanatoria would result in the greatest good for the greatest number in the shortest time.

There is no single heading in this paper that does not call for a lengthy and exhaustive article, but it has been handled as briefly as possible and much omitted. It may, however, give a vague idea of the work yet to be accomplished before tuberculosis can be cured, or even partially controlled.

RETROVERSION AND DESCENT OF THE UTERUS.

By G. H. MURPHY, M. D.,
Grace Bay, C. B.

(Read before Medical Society of Nova Scotia, Sydney, July 8th, 1909.)

SOMEONE has defined a woman as a beautiful creature composed of a uterus with other less important parts built about it. It was a somewhat quaint way of referring to the important bearing of this organ upon the entire female mechanism; and I doubt not that, should we let our minds wander 'mid our experiences as general practitioners, we should find abundant evidence to convince us that the majority of the ailments of our female patients are directly or indirectly the result of pathological conditions of the uterus. The quack knows this to be, in the main, true; and, consequently, the advertising columns of the daily papers abound with all sorts of exaggerations of the remedies, medical and instrumental, for the cure of diseases of the female generative organs. No class of persons are so imposed upon by the nostrum vendors, the faith cures and the Morrissey fakir, as these frail, neurotic women who have gone the round of many years with uterine prolapse or some allied uterine disorder. Missing most of what is best in life and thus drawing from fate little besides the dregs of existence, 'tis little wonder they should become the most morose, most pessimistic and neurotic people in the world, and that we should so often find them railing at the "slings and arrows of outrageous fortune."

I have in my practise a woman who has had complete prolapse during the last twenty-five years. She is a nervous wreck, and not only suffers herself but makes life miserable for everyone about her, not even excepting her medical adviser who in this instance has added to a number of adverse conditions the circumstance of her inclusion among the patients of his contract practice. She is never free from aches and pains and burning sensations and cold sensations and hot flushes; and during the first year of my practice, when I was more assiduously polite and considerate than I am now, I was often obliged to sit and listen while she recounted with detailed precision the various eccentricities of her multitudious symptoms. An old laceration of the cervix and perineum testify to the indirect cause of her years of misery. She always refused operative treatment and went through several courses of pessaries without any apparent advantage.

I mention this case as a sample of a class, because I am arguing that neurasthenia is an almost infallable outcome of untreated or improperly treated displacement of the uterus. The dragging pain, the reflex disturbances, the consciousness of being afflicted with a sexual disease, all logically tend to the production of neurasthenia. I believe it is fairly well know among us that even among men neurasthenia is a very common sequence of protracted trouble of the sexual organs. An ordinary varicocele may cause discomfort enough to set him thinking and brooding and reading quack descriptions of the terribleness of his affliction, until finally,

if left unenlightened and untreated, he becomes a neurasthenic.

The most common displacement and the one which is the most far reaching in its results of the chronic ailments of the uterus is, without doubt, retroversion and descent. One seldom or never finds retroversion without some degree of prolapse. Retroversion would seem to be prior to the prolapse, the latter starting as a first grade in a sequence of downward displacement of which the retroversion is the beginning.

Causes of Retroversion and Descent.—One might divide them into those residing in the normal uterine supports and those residing in the uterus itself. What the normal uterine supports really are seems yet to be a subject of some controversy. For the purposes of this paper I shall take the grounds which seem most consistent with the simple mechanical law of support as found in the human body, which is supported by the analogy of the other organs of the body and which seems to accord with the dictates of common sense. Therefore, I claim that the normal supports of the uterus are the ligaments, and not the levator ani muscle or any part of the pelvic floor. What are the ligaments for if not for its support? No organ in the body is better provided for in the matter of ligaments. They are eight in number, of which all but the round are formed by folds of peritoneum. Supporting the uterus in front is the anterior ligament; behind the posterior; antero-lateral, the round; and below near the cervix, the sacro-uterine, containing besides peritoneal tissue muscular fibres as well.

All these ligaments are attached to the pelvic bones, and are able to hold the uterus in place so long as they are not damaged by pelvic inflammations, or other causes tending to weaken their tone; by congestion of the uterus and its appendages, or any condition which by increasing the weight and volume of the uterus make extraordinary demands upon the suspensory efforts of the ligaments. A torn pelvic floor may in this way act as a factor in promoting descent by the formation of a rectocele, thus adding a new force pulling in the downward direction. Again, infection may enter here setting up enough pelvic inflammation to permanently weaken the uterine ligaments. That it is the new force which the rectocele creates in the case where the perineum is torn down to the rectum but not through it, that in time pulls the uterus down, and not the weakening of the pelvic floor, per se, is supported by the evidence of Dr. J. Riddle Goffe, of New York, who states that, in cases where the rectum is torn completely through and where therefore a rectocele will not form, clinical experience shows that the descent takes place. Again, the clinical fact that we find retroversion and descent in virgins where a strong pelvic floor exists must denote that other causes than the ones indicated disturb the functions of the uterine ligaments. Here, I believe, direct injury from a fall, heavy lifting, or any sudden exertion may produce retroversion with some degree of descent. I have had a few cases of this kind, due, I believe, to such causes. Once retroversion takes place the condition is pretty sure to get worse. The tilting backwards of the uterus constitutes a direct impediment to the return of blood in the sacro-uterine ligament, and the body of the uterus becomes congested, swollen and tender. This large congested uterus naturally tends to increase the descent, and the condition becomes progressive. The pulling upon the broad ligament disturbs the venous circulation

in it, the result being general pelvic congestion in which the ovaries will sooner or later share. When this happens, we are likely to have one or both ovaries prolapsed. This, of course, further disturbs the pelvic circulation, further weakens the pelvic ligaments and adds to the pain, discomfort and distress of the patient. Then there are leucorrhœa, dysmenorrhea, dragging pain in the back and general pelvic discomfort; and if the patient is not already a neurasthenic, she is in a fair way for becoming one. There will be vesical disturbances and constipation. Pain and discomfort on defecation may become a symptom.

Causes that begin primarily in the uterus have regard to any of the pathological increases in its size and weight. Perhaps the most common one is subinvolution. A woman leaves her bed before a safe degree of involution has taken place and assumes her household duties, which, as we know, among hard working people are often of a very arduous character. All the uterine supports are sharing in the general involutionary changes; and, when the extraordinary strain to which those conditions give rise begin to operate, there is great danger of retroversion and descent taking place, chronic endometritis, metritis, tumours, etc., tend to the same result by increasing the weight and weakening the tone of the uterus.

Treatment.—The question one must decide in those cases is between operative and pessary treatment; and the decision must always, I suppose, be influenced by the individual characteristics of the case. When but simple retroversion exists with a slight or moderate degree of descent and a good pelvic floor, it may be a rational procedure to attempt to keep the uterus in place by propping it up with a pessary, with the hope that the ligaments will regain their tone, and if the uterus is congested and heavy that it may regain its normal consistency. But, making due allowance for the number of times this mode of treatment succeeds, the fact remains that it is so often unsatisfactory and disappointing that one wonders if it would not be better to discard the use of pessaries altogether and advise operation in almost every case. I am going to venture the statement that in every case where there is much descent, operation should always be the treatment. This contention bears especial emphasis for the class of women whose duties keep them much on their feet and who may not choose the hours or the quality of their work.

Where pessaries are alleged to have effected a cure there still remains the slowness of the process, the disagreeable features it entails to the patient in having to have them constantly removed and replaced, besides the discomfort that even a well fitting pessary may occasion. On scientfic grounds arise the objection to the chances of introducing sepsis, the danger of erosion of the lining membrane, thus opening up channels for infective material to gain access leading to serious pelvic complications. If left in too long they certainly do untold harm. Three years ago, I had a woman come to me complaining of pelvic pain and discomfort, profuse leucorrhœa, dysmenorrhœa and menorrhagia. In giving her history she mentioned two years previously she had been treated in an American Hospital for "falling of the womb," that she got no better, had great discomfort and pain ever since and was getting much worse; she had not consulted a physician since leaving the hospital and was taking douches. I made an examination and found a large, hard pessary wedged partly be-

hind and by the side of the cervix. It was ulcerated into the fornix and lateral wall of the vagina and the cervix so deep that it was removed with some difficulty, the parts bleeding freely on its removal. Needless to say the uterus was still retroverted and prolapsed. It was large, soft and tender – endocervicitis, endometritis, septic vagina and, withal, a rather disagreeable condition of affairs. She knew nothing of the existence of a pessary and was somewhat surprised when I showed her what must have been a veritable instrument of torture during two years. At Soho Hospital for Women, London, with a large out patient department and where pessary treatment is much in vogue, I have watched them come there week after week and month after month to have these pessaries removed and replaced and as far as my observations went the number of cures resulting was not calculated to enhance one's admiration for this particular form of treatment. In France to-day a strong antipessary sentiment is rapidly gaining the support of the profession, and a similar feeling prevails in the United States.

It would seem, then, that in all but the rare cases where special contraindications exist, the better, more logical and more satisfactory treatment lies in operative measures, and in their adoption early enough to anticipate the evil consequences to which retroversion and descent give rise. Admitting these premises, the next thing to decide upon is the most rational operation to employ. They are numerous and each has, I suppose, its special merit; but on general principles the ones that have to do with strengthening the normal uterine supports, that is the ligaments, or bringing an additional ligament to their aid, would seem best caculated to meet the needs of the situation. In the former class comes the methods for shortening the round ligaments, in the latter, ventrosuspension and fixation. The external Alexander must always be limited in its application since, where pelvic adhesions exist or where there is any disease of the ovaries or uterine appendages, the disadvantages of working outside the peritoneal cavity are of course apparent. In suitable cases the operation is ideal, and Dr. G. P. Noble reports but one failure in two hundred operations. In any, then, but select cases opening the abdomen and dealing with the ligaments from inside is the proper proceedure. In Nobles' modification of the Gillian operation the ligament is picked up about five centimetres from the uterine junction, and a point midway between this and the internal abdominal ring is sutured to the junction of the ligament with the uterus. The peritoneum is perforated anteriorily on the broad ligament and the loop drawn through to the internal ring and then around to the rectus muscle perforating its outer border to the anterior sheath of the rectus to which it is stitched. I have had a little experience with this operation, and certainly it seems to be an admirable procedure. It overcomes what Noble says is the objection to the Gillian method, which operation divides the pelvis anterior into three segments, any one of which may act as a pocket where a loop of bowel may find its way producing strangulation.

In ventro suspension one follows nature's plan of suspending the uterus by using a fold of peritoneum, with this difference, however, that in the former, the attachment is to the pelvic bones; in the latter, to the abdominal wall. It holds the uterus up and anti-verted and does not interfere

with the enlargement of pregnancy. But the enlargement of pregnancy interferes with it, and thus the ligament may become lengthened forming a dangerous band which may produce strangulation of the bowel. This constitutes the real objection to the method. Dr. W. J. Mayo refers to the unsurgical character of the operation by saying that no surgeon while operating in the abdomen would close his incision and leave a band of adhesions extending from the abdominal wall into the pelvis. Yet this band is what one may expect to find where pregnancy has followed ventro-suspension. When it does not, I don't think the objection necessarily holds good. A few weeks ago I operated on a ventral hernia in a woman who three years previously had had a ventro-suspension of the uterus, and I took occasion to examine carefully the condition of affairs. She had not been pregnant in the meantime. The uterus was in its normal position. The new ligament was 1.1½ in. in length. It was strong and firm exhibiting all the characteristics of a ligamentous reduplication of peritoneum. Its new function had apparently induced such changes in its structure as would give it the necessary strength. It was so nicely wrapped about with adhesions to the peritoneum in front right down to its point of attachment to the uterus, that there could be no possibility of bowel strangulation taking place. Of course, it seems clear enough, that had pregnancy intervened, the necessary stretching might give it a different and less commendable character.

Ventro-fixation where the top or posterior surface is fixed to the anterior abdomen wall is, I think, universally condemned before the menopause; and it is difficult to see why it should be adopted at any time when round ligament shortening or ventro-suspension will give the same effect and does not present the illogical features of converting a moveable pelvic organ into a fixed one. The operation which I always saw done at Soho Hospital, London, was ventro-fixation and the surgeons there taught that it offered no interference to the normal development of pregnancy, or to parturition. This, they claimed, was due to the fact that the fixation was made low down on the anterior wall of the uterus. The upward enlargement of the uterus was mainly through the fundus and this was not interfered with. However this may be, I do not know, but I know my next neighbour delivered a woman some time ago where fixation of the fundus had been performed; and, although an expert obstetrician, he experienced such difficulties that he will probably go on remembering his experience throughout the years.

Whatever operation be decided upon, I think everyone is agreed that a torn perineum or a lacerated cervix should be repaired and curretage should be performed as preliminary steps. Whichever view one may take of the relation of the pelvic floor to retroversion and descent, ordinary surgical instinct suggests its restoration to a normal condition, and clinical observation proves it a valuable factor in the whole operative procedure.

PHYSICAL DEPARTMENT EXAMINATION.

By DONALD C. MALCOLM, M. D.,

St. John, N. B.

(Read before N. B. Medical Society, July 21st, 1905.).

PRESIDENT AND GENTLEMEN,—

LAST winter, the board of directors in the local Y. M. C. A., appointed me medical examiner to the institution. The medical gentleman, who had the arranging of the programme for this meeting, wished me to tell some little story of what I encountered in the work.

The examinations were principally to cover the Boys' Classes, to safeguard them, by foreknowledge, from any unsuspected lesions.

In all, I examined some 117 boys, ranging in age from 12 to 17, and in size from 4 ft. 6 in. to 5 ft. 9 in. Not a few of the smallest were 15 years and over.

As a rule, it is the healthy boy (to all appearances at least) who is sent to partake of the gymnasium privileges. Too often, the parents and friends of the weakling believe him to be too frail for such exercises as are there indulged in. So has it been as far back as I can remember, and so it seems it will continue to be.

Weaklings are the very ones who should be sent to the gymnasium, where their deformities could be seen, and suggestions offered and put in effect for the bettering of their bodily needs. Too many parents try to close their eyes at their children's deformities, hoping against hope that a kind Providence will cause them to outgrow their defects. Only in later years do they realize the mistake they have made. One has only to see a few of the cases which have been so wonderfully helped by systematic exercises to be convinced of the lasting benefit derived from this source. One authority has stated that between the ages of 12 and 24 is the proper time for exercise to be of any avail. Hence, the necessity of correcting their ills and deformities at the pliant ages, which ages are found in the boys' classes of the Y. M. C. A.

Graded exercises are of course the necessary thing. Just as one drug is called for in certain cases, yet does not apply in another, so, one exercise which is very beneficial to one boy, is altogether out of place for the next youngster. One boy requires one set whilst another requires a totally different set, but where there are so many in the regular gymnasium classes, 30 to 45 or more, such grading is out of the question, and only general exercises striking a good average for the class can be satisfactorily gone gone through. When special exercises are indicated, as in the various curvatures and the like, the cases are treated in the individual, and a course set and supervised to meet the individual needs.

The boy with the cardiac lesion is not allowed to over-exert himself at the games, etc., etc., but is taught to take things in moderation. Even when he does forget the caution and exercises to so-called excess, so great is the compensatory power of youth, that such boys seldom or never show signs of embarrassed circulation.

Once the examination is past, my part ends, and the physical director works upon the report, where special attention is necessary. What forms of exercise he imposes upon the individual cases, I cannot say. The routine work consisting of marches, calisthen-

ics, bar-drills, club-drills, German-horse work, games and running.

Most of the examinations were made, after light exercise had been undergone, as the members were usually on the floor some time before I arrived. This accounts for the increased pulse-rate (averaging 120 beats per minute). In some, who came directly in from hard exercise and running, it ranged from 120 to 144, though fully one-half showed only rates of from 88 to 120. Most pulses were full, strong and regular, such as one would expect to find in a robust boy of the age.

The few who presented lesions were as follows:—

Cardio-Vascular System.

One had an irregular beat, though I could find no organic trouble.

Two had a soft systolic murmur at the apex, which in either case was transmitted towards the axilla for a distance of about three inches.

One had a loud booming systolic murmur at the apex, heard over the cardias area and transmitted to the axilla.

All showed a sharp closure of the Aortic and Pulmonary Valves, but three had this more pronounced at the Aortic, and one at the Pulmonary, than is ordinarily found.

All these heart cases gave a history of rheumatism, dating back as a rule for a number of years. fff

None of these boys' vessels showed any hardness, all being soft and elastic.

Respiratory System.

Three had a slight Bronchitis, the rhonchi being heard over both lungs equally well.

A fourth, similarly ill, had a few crepitations present in the apex of the left lower lobe, heard at the lower angle of the scapula.

His father had died of pulmonary tuberculosis the year before, knowing which, set astart in my mind the possibility of his having the same disease. I did not get any sputum, but later examination revealed the absence of the former finding.

Taking into account the fact that these findings were made mostly in January and February, it will be readily seen that a very few indeed were afflicted with colds.

Locomotor and Integumentary Systems.

Apart from two obese boys, the majority were of the lank, not overly burdened with fat type of boy. Some few presented facial acne, and more had a similar condition of the chest, back and front.

No boy had a hernia, which is considerably better than the average found in growing boys of other Associations. Our local physical director tells me that the average is one in 50 in the statistics for the Boys' Branches.

About half a doze nshowed pigeon-breast, as well as other signs of rachitis.

No deformities from old fractures were found, and if any had taken place, the results were assuredly good. fffOne boy had a slight lumbar kyphosis, the convexity being to wards the right.

Glandular System.

Only one fellow had Adenoids of any notice, and this was associated with enlarged tonsils, which half filled the pharnyx.

Another boy had habitually enlarged tonsils, and besides was extremely fat. Though obese, he was quite active and well able to take part in the exercises and games.

Some two or three had cervical glands more easily papable, than is

ordinarily found, and two others had the puckered scars of glands which had suppurated in years gone by. None of the palpable glands were markedly large, and none of them were suppurating at the time.

Digestive System.

From the dirty, tartar covered teeth with cavities, to the well kept perfect teeth, were present, but I am happy to say that the latter predomi-nated.

No gross lesions were found in any of them, in this system.

C. N. S.—The cranials in all were functioning perfectly, as were the spinal and peripheral trunks.

G. U. System.

No particular attention was paid to this system, but to all physical appearances they were well enough in this way, and coming on in good shape towards full manhood.

Taken altogether, they were as good a class of growing boys physically as one could well select.

The only senior I looked over was a young Frenchman, who had been exempted from military service at home, because of his heart. Here, he was not in the best of health, being off his food, and had considerable to worry him.

There was no lesion of the valves, nor enlargement, but there was much irregularity in the beat, and which lacked the proper force. Its action was that found in a person, long subjected to nervous and mental strain, where the regulating nervous inhibition is wanting, resulting in fluttering and irregularity.

I tried to get data of the statistics compiled from the United States and Canadian Associations, as the meagre facts of our own first season are but as a drop in the bucket. The time was too short to secure the necessary facts and figures, which I am sure would be highly interesting, and would have added length and interest to this brief sketch.

THE ART OF PROGNOSIS.

By A. ROSS, M. D.
Alberton, P. E. I.

(Read before Maritime Medical Association, Charlottetown, July, 1909.)

IT is rather unphilosophical to speculate about the future. As long as one does the best he can under the present circumstances what need to waste time with vain speculations. It does no good and often leads to wrong prophecies and painful explanations. But while human nature is what it is and we are what we are whether willing or not the prophet's mantle is thrust upon us and we are expected to give to the patient and his friends a forecast of his ailment. To be able to do so shrewdly enhances one's skill in their minds more than perhaps anything else in connection with the medical side of the profession. A prognosis that presents the sequences of symptoms and the ultimate result is to them a convincing proof that a physician understands his business. And there is a good deal in it. If they happen to be ignorant there appears to them a sort of a superstitious mystery about it, which if directed in the right channels will do no harm, and may lead them to do for you what they otherwise would not.

There are two sides to every prognosis. There is the forming of a prognosis and the communicating of it. The former is scientific, based on statistics and experiences and is a sort of general summing up of things. The latter is an art.

The forming of a prognosis is based upon many factors. The diagnosis, the treatment, the surroundings, the constitution of the patient and the uncertainty of human life enter into it. In order to form a trustworthy prognosis, one must be a keen diagnostician, be up-to-date in treatment, must know his patient, have common sense and sound judgment, and must often have intuition or sense akin to instinct, a sense acquired only after a long experience.

Speaking of intuition, and its bearing on prognosis, I have often been called to see a patient who presented no serious symptoms when weighed in the balance of reason and experience, but yet I have felt a sense of impending disaster. There is a vague, undefinable something about the case that keeps telling me my patient is going to die. It seems to be a sort of premonition, or as the Scotch would say a sort of second sight, but then it is strengthened often each visit, an uncanny ghost that reason cannot down. As a rule my patient dies. I have had this experience often and on several occasions very vividly. I account for it as a general impression received from many little things about the patient which separate are nothing and are overlooked, but which when combined convey to one, without his being conscious of it, a most unfavourable impression. When by intuition I receive this impression I give it great weight in my prognosis.

After we have formed our prognosis the question of communicating it to the patient or his friends arises. There is usually no difficulty. But when the outlook is bad—and it is in those cases our opinion is oftenest sought—we are presented with a problem that requires tact, a judic-

ious selection of words, wisdom and a keen knowledge of human nature.

We influence our patients by our personality as well as by our treatment, and perhaps in no way, more than in a happy way of giving a prognosis or otherwise. There must ever be present with us the fact that hope in his own recovery, and confidence in us, are for the patient forces that make for a cure. Anything that diminishes that hope lessens the patient's chances of recovery. So that a bad prognosis helps to bring about the condition foretold. There is no doubt that a bad prognosis lessens confidence. The bearer of evil news hath a loosing office! No one in a tight pinch likes to have a croaker about. We like to have a cheerful body, who keeps telling us things we like to hear, even if we know he is lying.

A bad prognosis may be made to appear worse in the manner of telling. If you tell your patient he is no better to-day, he naturally concludes that he should be better and of course thinks he is worse. Whereas if you had told him he is no worse to-day, he does not expect that he should be better, and is satisfied. If he is doing badly he may be told that many do a great deal worse. It is better to tell him the chances are evenly balanced, than that it is a toss-up with him. If he looks on the dark side we direct his attention to the silver lining in his cloud. We all have a whole stock-in-trade of little pleasant nothings to keep our man in a cheerful, hopeful frame of mind. How often do we magnify the good and steer over the bad, and fill our patients full of a hope we do not feel! To be able to do this without *telling* lies is a very fine art.

It is bad policy in an incurable case to tell the patient there is no hope for him. As a rule he will leave you and try some one else who will tell him there is a chance. When he dies his friends do not hold it against the man who told him to hope on. The tendency is to fear you for being over candid. I recollect several instances where I lost the confidence of families by being too candid. I now scarcely ever tell a man in express words he is going to die. I tell him he has, we will say cancer, consumption, or diabetes, and let dawn on him what the end will be.

I believe one is perfectly justified in lying to his patient if it is for his good. The motive is what gives a moral complexion to the act. So that an expression contrary to fact, calculated to do good, may be called a lie, but it is not, or to say the least it is a good lie.

In the matter of prognosis generally speaking we do not experience much difficulty with the patient himself. All he wants is encouragement. It is with the patient's friends with the difficulty often comes in. There are many kinds of them and the prognosis must vary as the kind. We have the timid, the nervous, the loving, the fearful, the disobedient, the purse-proud, the boors, the whiners, the know-it-alls, etc., etc. To be able to deal with them all in the best way and at the same time to do the best by the patient requires the wisdom of Solomon. To say the least it requires a vast fund of knowledge not found in our books. Time will not permit me to deal with but one or two types.

As a rule to any of them I do not give a prognosis unless it is insisted upon. Then after referring to the uncertainty of human life and the fact that every sickness is dangerous I tell them plainly what my opinion is,

without reasons. If the outlook is very grave I caution them against telling it to the patient. Suppose I find that new symptoms have developed which alter my prognosis I call attention to these and tell them I have changed my mind.

In dealing with the ignorant I assert my authority. I either speak ex cathedra or in parables, usually taking my illustrations from their occupations and letting them draw the inference.

I ask the whiners, who expect the impossible in *their* case, if they think the Almighty is going to show them special favors which He does not show to the rest of humanity. I call their attention to the fact that all diseases are controlled by laws and that those laws are not going to be altered to suit them. Instead of flying in the face of impossibilities they must cultivate patience, and that probably the illness was sent so that they might have an opportunity to cultivate this admirable virtue.

In dealing with the fault-finding boor who impugns your skill, and questions your motives and is ever ready to make a scape-goat of you for his own sins of omission and commission, it is best to have nothing to do with him, or if you cannot, emphasize your prognosis with your fists.

The know-it-all who asks you a whole lot of inane questions more to show his own knowledge than to elicit information, you can deal with in either of two ways. Ask him questions that will bother him, or in answering his questions ball him up with technicalities and scientific terms —mystify the cuss. He will bother you no more for he does not want to confess he does not understand you.

The kind, loving souls who are not there to ask questions but to help you all they can in fighting the grim enemy, "grapple them to thy soul with hooks of steel," for they are the salt of the earth. Their sublime confidence in you while it makes you feel mean, calls forth the best that is in you. Amidst many discouragements they act as a tonic and make life professionally worth living.

Thus we see the many phases of human nature. It becomes us in order to be all round men to study it well. We do not find its lessons in the textbooks but in the deep wells of experience. To the young practitioner human nature from the physician's standpoint is largely a sealed book, to be read only by the lamp of experience. It is unfortunate that in our schools and colleges no attention is paid to this great subject, a lack of knowledge of which often mars the brightest college career. It is of vastly more importance than many of the dusty things that are taught.

In studying human nature we will learn many things in connection with the profession, but nothing more important than the art of giving a shrewd prognosis.

CASE REPORT.

By ANGUS A. McLELLAN, M. D.,
Summerside, P. E. I.

(Read at Meeting Maritime Medical Association).

I WISH to state briefly a rather peculiar case I had two years ago. On June 12th, 1907, a young man consulted me for Gonorrhœa; age 24. His mother, two sisters and three brothers died T. B. C. Fairly healthy looking but always had flushed cheeks. Had been suffering from a discharge 10 days before I saw him. Also complaining of a headache he had for some weeks. 15 days afterwards I was called to his boarding-house in the evening and found that he had been vomiting all day and had a a severe pain in back of head. Had not slept any the night before on account of headache. Pulse, 80; temperature, 101 2 5; Examination of all parts of the body revealed nothing abnormal. The next day his temperature was 102, pulse 80, still complaining of pain in occipital region. Vomiting somewhat better, bowels could not be moved except by strong cathartics. Third day his temperature was the same, 102; but his pulse dropped to 64 and irregular. Somewhat irritable to light and noise. Fourth day temperature raised to 103 and pulse to 74, still complaining of headache. Blood examined for typhoid, negative results. Fifth day, pulse and temperature the same with no let up to pain in head. Sixth day complained of stiffness in neck which was tender on pressure. That night he became somewhat duller, pupils slightly contracted. Seventh day: Much duller. When spoken to answered with a slow, indistinct drawl. When awake his position was on his back, but slept usually on his side. side. "Kernig's sign" gave no satisfactory results one way or the other. Eighth day: Dull, delirious, and muttering in a state of stupor. Respiration always running about the same, 20, with an occasional sigh. At the end of the second week temperature dropped to normal. He remained practically in this condition for three weeks with intervening days of brightness. About the fourth week he recovered from the stupor but became so irritable, insulting and offensive that both nurses asked to be relieved from their duties, and he was left to the tender mercies of his sister. He had now being about a week taking a fair amount of nourishment, gaining in strength and resting fairly well at night but always had a dull feeling in the head and still had the same indistinct drawl. At the end of the fourth week was allowed to sit up. The second day up he stole out of the house and went down town where his friends were alarmed at his vacant stare and foolish talk. At the end of six weeks he went to country where he remained for some time. In three months he returned to the office but could not study. Could not remember a sentence. He would read and had to give it up. I kept him practically in the open air for six months, where with a great deal of difficulty that he progressed any. In fact he told me this spring, nearly two years after his illness, it was the first time he could study with a degree of satisfaction. A strange thing about it was on the third night when I thought his mind perfectly clear I was called out twice to treat an acute attack of hæmorrhoids which stayed by him for three weeks and he never knew he had them till six months afterwards I accidentally mentioned the fact.

He is now as healthy as he was three years ago. Briefly, that's my case.

CORRESONDENCE.

The following brief story of the organization and growth of a post-graduate society in London will no doubt interest many of our readers, owing to the prominent part taken in the project by Doctor F. L. S. Ford, of New Germany. This society will prove of considerable value to those intending to pursue post-graduate studies in London

To the Editor:

SOMEWHAT after the pattern of the Post-Graduate Medical Societies of Berlin and Vienna, a new Society was organized in London in May of this year, 1909.

Doctors Gilbert, of Connecticut; S. C. Slocom, of Oregon; and F. S. L. Ford, of Nova Scotia, took it upon themselves to call a meeting of the men doing post-graduate medical and surgical work in London to consider the advisability of organizing a society.

The meeting was held in Dr. Ford's bedroom, Russell Sq., and over a dozen men, including the following, were present: Slocom, of Oregon; Gilbert, of Connecticut; Franklin, of Nebraska; Atlee, of Massachusetts; Wylie, of Montana; Drs. Macoun and Whitman, of Ontario; Drs. J. A. Sponagle, F. S. L. Ford, Duff Murray, of Nova Scotia; Drs. Lang and Ritchie, of Manitobia, and several others from New York, Montana and Ontario.

Dr. Ford was appointed temporary president and Dr. Slocom, temporary secretary. After a full discussion by all present it was decided to proceed with the organization of a Society having the following objects:—

1st. The promotion of social intercourse between medical post-graduates in London.

2nd. The provision of information for men desiring to do post-graduate work in London as to the different courses given and the best places for special and general work.

The first to be brought about by stated meetings at a suitable place where some man connected with the London hospitals would address the Society on a scientific subject, after which a dinner would be indulged in.

The second object to be attained by establishing a bureau of information at some place where a register will be kept for all who wish to take advantage of the Society.

A small registration fee was to be charged which would entitle the member to printed matter relative to the courses given in London and also to enjoy all the other privileges of the Society.

The Russel Square meeting was adjourned for a week and the second meeting held at the "Polyclinic," Clinics St., W. C. A larger number were present, including several prominent London surgeons and physicians who expressed themselves as heartily in accord with the movement. Organization was effected under the name of "The Overseas Medical Post-Graduate Society of London," to include in its membership all English overseas post-graduate students doing work in London.

The temporary president and secretary gave notice that they were leaving London the following week and declined re-election. Dr. Macoun, of Ontario, was elected president, and Dr. Wiley, of Montana, formerly of Fredericton, secretary. Various commitees were appointed, routine work done and a draught of By-Laws submitted by Dr. Gilbert, adopted. Meeting then adjourned. Since then meetings have been regularly held at the oldest Chophouse in London, "Ye Olde Cheshire Cheese," a place rendered almost sacred as having been the favourite resort of Dr. Samuel Johnson and other noted men of that

period. This house is situated in Fleet Street, nearly opposite the entrance to the Middle Temple, and its interior is just as it was a hundred and fifty years ago.

A recent communication from London states that the Society is flourishing, having now over fifty members. The Society is being addressed by celebrated men, the last being Mr. Arburthnot Lane, of Guys.

Any of our readers going to London will find it greatly to their advantage to keep "The Overseas Medical Post-Graduate Society of London" in their mind. W. H. McD.

PERSONALS.

DR. C. S. MORTON, son of Rev. Dr. A. D. Morton, who practised medicine for a number of years at Port Greville, has returned from Great Britain, where he has been taking a post-graduate course, and has located on Pleasant Street, this city.

Dr. G. A. MacIntosh, formerly on the staff of the Nova Scotia Hospital, who has recently returned from post-graduate work in London, has opened an office on Robie Street, this city.

Dr. James Ross, of the editorial staff of the MARITIME MEDICAL NEWS, was married on 12th ult., to Miss Lillian M. Reeves, of this city, formerly head nurse of the Lowell Hospital.

Dr. J. Stuart Carruthers, of this city, was married reeently to Miss Teresa Crosby, daughter of A. B. Crosby, M. P.

Dr. Arthur Johnson, son of Rev. Dr. Johnson, of the Wesleyan, was married recently to Miss Lena Heartz, daughter of Rev. Dr. Heartz, of Amherst. Dr. Johnson will locate in Toronto.

Dr. A. I. Mader, who recently went to Great Britain for a trip, became suddenly ill in Edinburgh, and a laparotomy was performed by Mr. Caird of that city. Particulars have not been received, but the latest news brings word that he is recovering.

Lieut.-Col. G. L. Foster, Principal Medical Officer of the Maritime Provinces command, has gone for a trip to China. Lieut.-Col. Bridges, of Fredericton, has taken up his duties until his return.

Dr. R. A. H. MacKean, of Glace Bay, will have the heartfelt sympathy of the profession in the sudden death of his beloved wife, which occurred on the 11th inst.

Dr. Fred. Miller, of Saranac, who has been visiting his relatives in Prince Edward Island, has improved in health considerably. Dr. Miller has been a recent visitor in Halifax before again taking up his work at Saranac.

CURRENT MEDICAL LITERATURE.

THE *American Journal of Surgery* will produce in December a Philadelphia issue of their journal, the subject matter of which will be composed entirely of contributions from among the leading men of that city. Among the subjects to appear and their contributions are as follows:

"A Consideration of the Diagnosis and Treatment of Retro Displacement of the Uterus,' by E. E. Montgomery, M. D., Prof. of Gynæcology, Jefferson Medical College.

"Polypoid Growth of the Rectum and Report of a Recent Case," by Lewis Adler, Jr., M. D., Prof. of Diseases of the Rectum, Philadelphia Polyclinic.

"Tumours of the Urethra in Women," by Barton Cooke Hirst, M. D., Prof. of Obstetrics, University of Pennsylvania.

"The Control of Hæmorrhage During Pregnancy," by Edward P. Davis, M. D., Prof. Obstetrics, Jefferson Medical College.

"Cyclodialysis," by Walter L. Pyle, A. M., M. D., Ophthalmologist to the Mt. Sinai Hospital, Asst. Surgeon of Willis Eye Hospital, etc.

"Roentgen Treatment of Malignant Diseases," by Charles Lester Leonard, A. M., M. D., Ex-President of the American Roentgen Ray Society.

"The Conservatism of the Middle Turbinated Body," by William V. Hitschler, M. D.,

"The Diagnosis and Treatment of Ectopic Pregnancy," by F. Brooke Bland, M. D.

The following well known surgeons will also contribute and their titles will be announced at a later date.

Ernest LaPlace, A. D., A. M., M.D., Prof. of Surgery, Medical Chirurgical College.

Prof. William Campbell Posey, Prof. of Ophthalmology, Philadelphia Polyclinic.

John G. Clark, M. D., Prof of Gynæcology, University of Pennsylvania.

H. M. Christian, M. D., Clinical Professor of Genito-Urinary Diseases, Medical Chirurgical College.

John A. McGlinn, A. M., M. D., and others.

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CLINICAL DIAGNOSIS AND TREATMENT OF DISORDERS OF THE BLADDER. By FOLLEN CABOT, M. D., Professor of Genito-Urinary Diseases, Post-Graduate School, New York. Price $2.00. PUBLISHED BY E. B. TREAT COMPANY, New York, 1909.

This book, of some 200 pages, is divided into ten chapters. Hints on case taking, the anatomy of the bladder, kidney, etc., and urinalysis are briefly but clearly given. The author deals with the methods of examining the bladder and describes the technique of cystoscopy in an easily comprehended manner. The causes and treatment of cystitis and the diagnosis and treatment of senile hypertrophy will be found a valuable guide as one should expect from the author's large experience. Case reports given in the text further add to the value of this work. The illustrations, which are numerous, are well executed.

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CATHETERIZATION.

Cystitis has been found so often to follow not only a foul catheter but careless catheterism, that it is important to employ the most careful asepsis in the preparation of the patient, instruments, and the operator's hands. And if the patient should essay to catheterize himself the above precautions should be enjoined upon him. After catheterization it is well to instill a few drops of a 1.1000 solution of silver nitrate to the trigonum and throughout the urethra, and to administer by mouth sanmetto in teaspoonful doses, in a half wine-glass of warm water every two hours.

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GASTRO-INTESTINAL ANEMIA.

From a strictly scientific standpoint, the heading of this clinical note is no doubt incorrect, or at least faulty, as there can scarcely be said to be a true anemia, due to gastro-intestinal disease, that can be morphologically differentiated from the anemia which is secondary to other devitalizing disorders. At the same time, it is undoubtedly true that gastro-enteric disease, even the common functional dyspepsia, if sufficiently long continued, is productive of an anemic blood condition. It is a well recognized fact

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that auto-toxemia, resulting from the constitutional absorption of the products of intestinal putrefaction, is not infrequently followed by a generally devitalized condition of the circulating fluid. In such cases, while attention should primarily be directed to the gastro-enteric condition, the anemia should also be treated, in order to induce recovery in the shortest possible period of time. Care should be taken to avoid the administration of drugs that tend to derange the digestion. For this reason, the inorganic metallic salts of iron should not be given, as they are extremely likely to prove irritant, astringent and constipating. Pepto-Mangan (Gude) may be given, in such cases, with every assurance that the necessary iron and manganese will be promptly absorbed without irritating the gastric mucosa or inducing constipation. Children, especially, take it readily, because of its distinct palatability.

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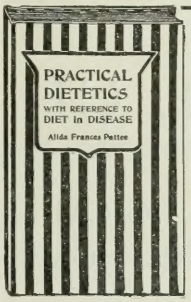

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'BARLEX' a concentrated Extract of Malt, possessing marked hydrolysing properties. It contains in their most potent form the organic salts, proteids and carbohydrates of the best Barley.

'BARLEX' stimulates functional activity of the whole digestive system, promotes metabolism, and plays the part of a reconstructive nutrient.

'BARLEX' increases the nourishing power of all articles of diet. In this way it assists in maintaining vitality and enhancing the strength of patients during convalescence from prolonged illness.

'BARLEX' WITH COD LIVER OIL

The addition of Cod Liver Oil to 'BARLEX' produces a perfect food, supplying the fat and carbohydrates so essential for maintaining the heat of the body. The ferments of the 'BARLEX' render the oil more readily available for assimilation.

This preparation is particularly efficacious when administered for Bronchial and other Catarrhal conditions of the respiratory organs.

For children suffering from mal-nutrition no preparation can rival 'BARLEX' with Cod Liver Oil. During the cold season it will be found most serviceable for growing and anæmic children.

'BARLEX' with COD LIVER OIL and HYPOPHOSPHITES

An ideal reconstructive nutrient, especially beneficial in convalescence and old age.

Prepared by

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